Dispatches on the Globalizations of AIDS

ONE DISPATCHES ON THE GLOBALIZATIONS OF AIDS

A Dialogue between Theodore (Ted) Kerr, Catherine Yuk-ping Lo, Ian Bradley-Perrin, Sarah Schulman, and Eric A. Stanley, *with an Introduction by Nishant Shahani*

As the first of three "dispatches" that are interspersed throughout this volume, the juxtaposition of voices gathered below serves to highlight the multiplicity of approaches among thinkers who are academics, artists, journalists, and activists (in many instances not mutually exclusive categories). Besides initial prompts, the lack of editorial curation hopes to preserve these differences in register rather than paper over them in the service of smooth consistency in style or tone. The term *dispatches* (or *palimpsests of insights*, as one of the volume reviewers usefully called them) captures these truncated glimpses or musings that are not always in direct or explicit dialogue with one another but still generate the kinds of scattered collectivities that lie at the core of the volume's conceptual emphasis on the multiple scales and calibrations of distribution.

The five contributors to this particular dispatch—Theodore (Ted) Kerr, Catherine Yuk-ping Lo, Ian Bradley-Perrin, Sarah Schulman, and Eric A. Stanley—were put together from a broader list of thinkers that we carefully curated, consisting of those whose ideas centralized AIDS scholarship and activism while also circling around writings on AIDS in more oblique and, at times, even seemingly unrelated directions. The rationale was to allow for the cross-cutting of ideas beyond the traditional frames of what could be understood as scholarship on HIV and AIDS, so that the writings in this volume (and the dispatches in particular) could create connecting threads between sites conventionally thought of as discrete and discontinuous. From

the congeries of names we created, the five selected for this "dispatch" offered precisely this combination of expertise on AIDS scholarship along with interests that could particularly offer a set of provocations in thinking through global frameworks. These include investments in ethics and theology (Kerr), security studies and Asian-Pacific foreign policy (Lo), the neoliberal politics of pharmaceutical marketing (Bradley-Perrin), critiques of homonationalism and gentrification (Schulman), and prison abolition and trans resistance (Stanley).

In terms of the form these dispatches would take, we arranged asynchronous rather than real-time exchange of writings, framed by two prompts for each dispatch. Such organizing had as much to do with logistical necessities, such as differing time zones and conflicting schedules, as with the critical orientations of the book. It is undeniable that such a non-coeval format has its limits—a potential loss of spontaneity that subtends the unpredictability of "live" exchange or the communal intimacies that can be forged with face-to-face or at least coinciding encounters. And yet there is something apposite about navigating the difficulties of achieving real-time connectivity in these dispatches on AIDS and globalizations. Globalization, after all, has been described as a phenomenon of hyperconnectivity that axiomatically transgresses space and time. But the celebration of its putative spatial and temporal condensations ignores the often alienating ways in which globalization also fragments and isolates, so that certain populations are left out of "real time" even as others benefit from economies of instantaneousness more immediately. Perhaps our inability to meet in real time constitutes a kind of instructive pedagogical failure. We might begin to understand globalization's compressed spatiotemporalities as those that truncate and "scatter" even as they purport to always connect and unite.

While the other two dispatches in this volume on the pasts and futures of AIDS are explicitly framed around logics of time, the "dispatches on the globalizations of AIDS" appear, at least superficially, as the anomaly. But in many ways, its intent is not dissimilar to the temporal structuring of the other two, by considering how globalizations implicate both "pasts" and "futures" (just as the dispatches on pasts gesture to futures and the dispatches from the futures often shuttle back to pasts). Framing these dispatches in temporal terms allows an understanding of both globalizations and AIDS as "nothing new," that is, as operating through long and prior geopolitical histories of imperialism and colonization but also as a flexible transnational practice that is constantly shifting and morphing through novel and reorganized mutations. In different ways, the contributors simultaneously recognize these

recursive repetitions and updated permutations through theorizations of the politics of time: for example, Kerr's attention to the "urgencies of time" so that we can unpack global histories of AIDS prior to the 1980s, Schulman's retrospective framing of AIDS before and after the fall of the Soviet Union, and Stanley's contention that our present definitions of AIDS and HIV are predicated on traces of the past that are imbued with the "haunts of conquest and chattel slavery."

Relatedly, the prompts to contributors were proposed with the intent to brush up against narratives of globalization's purported elastic transgressions (where the role of the nation-state seemingly disappears from view) so that we might begin to articulate how systems of management are calcified and intensified at precisely the moments in which they are thought to weaken or diminish in their sovereign scope. It is not without significance then that a recurring preoccupation through several responses below is a consideration of how the flow and exchange of liquids—blood, plasma, drugs, vaginal fluids, breast milk, semen—become sites of governmentality saturated by anxieties around contagion (most explicitly foregrounded in Lo's analysis of the nexus between the state and blood banks that precipitated an HIV outbreak in the Henan province of the People's Republic of China). Blood, as Stanley has similarly pointed out in another context, is charged with meaning "beyond its cellular capacity," telling us "stories" that "are as much about blood banks, platelets, and centrifuges, as they are about race, kinship, sexuality, contagion and the force of exile."[1]

The management of "dangerous" liquids thus informs the logics of globalization under which the fluid movement of capital functions in tandem with, and as an alibi for, the magnification of boundaries and fixities. The contributions in this dispatch thus explore how capital's liquid-like flows are predicated on the geopolitical governing of fluids in order to allow for surplus accumulation—"liquidity" in another sense—of easily accessible capital that ostensibly guarantees market stability, and which must therefore be inoculated from the unpredictable contaminations of bad blood. Since blood is crucial to biopolitical logics of slavery, dispossession, and antiblackness, it is not a coincidence that several contributors allude to the central place of racial capitalism in how AIDS crises get distributed. The term *racial capitalism* itself has its genealogies in Black Marxist traditions of Cedric Robinson, who pointed to the ways in which the "development, organization, and expansion of capitalist society pursued essentially racial directions."[2] In considering these "racial directions" in the context of AIDS, the contributors explore its dialectical operations. Mobilizing Ruth Wilson Gilmore's theorizing of ra-

cial capitalism, Jodi Melamed analyzes how Gilmore's definition of racism points to seemingly oppositional logics of connection and disconnection. For Melamed, the implications of Gilmore's understanding of racism as the "group-differentiated vulnerabilities to premature death, *in distinct yet densely interconnected geographies*," are not fully grappled with, if the italicized qualification is bracketed as a parenthetical afterthought.[3] Racial capitalism thus operates through both "dense networks" and "amputated social relations" that disconnect racial subjects from their humanity precisely "so that they may be 'interconnected' to feed capital."[4]

The antinomies of racial capitalism explain the contradictions at the heart of globalization—its supposed capacity to shrink and connect while actually exacerbating fragmentation and isolation. Ironically, the critique of globalization as a mode of "time-space compression" is often refracted through the lens of neoliberal multiculturalism, reducing it to the benign platitude of simply "the world becoming smaller." But as contributors in these dispatches usefully remind us, these "compressions" assume more literal and violent dimensions when considered in the context of racial capitalism's draconian projects of state-building—for example, imprisoned AIDS activists (Lo) as well as the carceral logics of prison expansion that have criminalized the HIV-positive Black body (Schulman). The bracketing of racial capitalism from the "stories" of globalization thus creates fictions of relationality and corporate largesse—for example, the pharmaceutical sponsorship of Pride parades or the "charitable" distribution of medicines by multinational companies that secure patents over generic HIV medications (as analyzed by Bradley-Perrin).

Melamed concludes her analysis of racial capitalism by suggesting that its dialectical contradictions "reveal its weakness as much as its strength."[5] For Melamed, a return to Robinson and Black Marxist thought allows for an understanding of relationality between past, present, and future that is not in the service of monetization and Black dehumanization. The "response of African people to being ripped out of webs of Indigenous social relations" continues to be one of "collective resistance . . . [in] the form of (re)constituting collectivities," writes Melamed.[6] The dispatches below, despite their asynchronous formats, are attempts to imagine collectivities beyond the truncations of globalizations' fragments. When Schulman contends that "we have not yet found" answers amid "fragments of stories," or Kerr writes of "alienating waiting rooms" that embody how "there is no privacy in living with HIV" even while "HIV has largely been privatized," they document the technologies of globalizations and racial capitalism that disconnect and sever us from the reconstitution of collectivities. But in these scattered fragments

are also "dreaming project[s]" (Stanley) of other times and places, of alterative genealogies of the past, and of reparative projects that gesture toward seemingly impossible futures.

—*Nishant Shahani*

Prompt 1

Nishant Shahani: From the very outset, discourses around HIV and AIDS have been implicated in global processes that impacted its cultural and epidemiological meanings. If AIDS, as Eric Cazdyn has pointed out, is not simply "the most perfect metaphor for globalization" but *is* globalization itself, what challenges do artists, activists, and scholars face in mapping the links between local and global AIDS in the twenty-first century?[7] How have these challenges morphed and shifted over time, but in what senses have they also persisted and remained the same?

Sarah Schulman: My first thought about international AIDS took place in September 1985, when I wrote the following piece for the *New York Native*:

> **AIDS Reported in the Soviet Union**
> **Sarah Schulman**
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> According to a story filed from the Soviet Union by United Press International, Soviet doctors have admitted that an undisclosed number of AIDS cases have been diagnosed there. The doctors are reportedly searching for a cure.
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> Although the Soviet Union does not admit to the presence of homosexuals or drug addicts among its population, official press reports have blamed the spread of the disease on these groups. They have also warned against sexual contact with foreign visitors including a forty-member homosexual contingent from the Netherlands to the International Youth Festival in Moscow this summer.
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> One doctor, Leonid Filarov, chief of the Odzhinkidze Sanatorium in the Black Sea resort of Sochi, said that some doctors believe that AIDS results from "mixed marriages." According to Dr. Filarov, "Mixed marriages can create genetic mutations, and it is possible AIDS could be a result of these marriages."
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> An annoyed woman at the office of the *Daily World*, the New York newspaper of the Communist Party, USA, told the *Native* that she had

"no information" and referred us to the official Soviet news agency, Tass. A representative there said that three or four articles on AIDS had been published in the Soviet Union, but that he had "no information." He did remember, however, that "a leading Soviet spokesman" believed that AIDS was the result of mixed marriages, but he could not recall which race the doctor had referred to.

Well, there is no more Soviet Union. The racist assumptions at the foundation of AIDS thinking are still active and dynamic, although they have shifted from race-mixing to the concept of the predatory Black male being targeted by HIV criminalization in the United States and Canada. The longstanding mythologies that Africa gave the world AIDS, instead of the other way around, have recently been addressed by studies showing that mass inoculation efforts carried out by the West in the Global South using multiple inoculations on one needle helped create the epidemic. But what really stands out for me is my own tentative voice in this piece. I am disturbed, annoyed, and offended that the Soviet Union is so prejudiced, but I also, clearly, have no idea that there will soon be a global epidemic of cataclysmic proportions. In a sense, this—my first glimpse of international AIDS—was experienced as an oddity. It also becomes apparent, upon rereading, that at this point in AIDS journalism, four years into the crisis, we were entirely grasping at straws. Any news could be important or irrelevant. There was chaos, not only in the newsroom where journalists themselves were dying but in our minds. We were sifting through glimpses, fragments of stories, eclectic sources, and endless overwhelming new information, trying to discern what really mattered, and what would take us to an answer to the problem of how to get AIDS out of our lives. This answer is something we have not yet found.

Catherine Yuk-ping Lo: Chinese president Hu stated in a 2003 public speech that "HIV/AIDS prevention, care and treatment is a major issue pertinent to the quality and prosperity of the Chinese nation." Similarly, Premier Wen asserted that "dealing with HIV/AIDS as an urgent and major issue is related to the fundamental interests of the whole Chinese nation."[8] The HIV/AIDS-security nexus was restated in the official 2004 "State Council Notice on Strengthening HIV/AIDS Prevention and Control." This document explicitly demonstrated the determination of the Chinese authorities in framing HIV/AIDS as a security problem of the country, stating that "HIV/AIDS prevention and control is linked to economic development, social stability, and national security and prosperity."

The HIV/AIDS-security rhetoric adopted by China in addressing HIV/AIDS can be contextualized in relation to the scandal of the "AIDS Village" (*aizibing cun*) in Henan, which garnered global attention by the international community in the early twenty-first century when Elisabeth Rosenthal published a series of reports in the *New York Times* revealing the government-supported blood-selling incident in the 1990s that caused a massive outbreak of HIV/AIDS in Henan. Since then, the Chinese government has been criticized and condemned on its capacity to attend to HIV/AIDS in China, raising questions about the legitimacy of the Chinese Communist Party (CCP). When I asked a human rights lawyer in Beijing whether HIV/AIDS remains politically sensitive several years after Henan, his answer was full of sarcasm: "HIV/AIDS is no longer a sensitive issue in China, because most of the infected individuals in Henan were perished with HIV/AIDS."[9]

The failure of the Chinese authorities in grappling with HIV/AIDS in the public health setting has exacerbated the prevalence of global HIV/AIDS-security discourse in China. Two respondents working in HIV/AIDS-related nongovernmental organizations (NGOs) based in Beijing and Shanghai, respectively, told me in 2011 that they are pessimistic that HIV/AIDS problems could be fully addressed in public health settings where the disease has stigmatized connotations. In China, the first cases of HIV/AIDS occurred among foreigners and homosexuals in the 1980s. Therefore, the Chinese authorities in the early years promoted the idea that HIV/AIDS only affected marginal populations and non-Chinese people. Zeng Yi, the chief of the Chinese AIDS Research Program, asserted that HIV/AIDS was a foreign threat. In this regard, the authorities perceived HIV/AIDS as a foreign disease and did not consider it a health threat to the nation. The misperception hence hindered the allocation of necessary resources to address the problem, causing the continuous spread of the epidemic in China.

The general population and even the well-educated Chinese middle class have an inaccurate understanding of how HIV/AIDS is transmitted even today. A university professor in Beijing told me, "One of my colleagues told students that HIV/AIDS is an airborne disease." A program manager of an HIV/AIDS-related NGO in Beijing explained, "HIV/AIDS-related stigma and discrimination is still severe in medical and employment settings. . . . Medical practitioners refuse to conduct surgeries for HIV/AIDS-infected individuals. In addition, infected individuals cannot work as teachers, civil servants; some companies or enterprises do not hire HIV-positive individuals." An HIV/AIDS specialist working in an international NGO in Beijing commented on the problem of HIV stigma in China: "Discrimination against HIV/AIDS-infected individuals is obvious in some workplaces, such as hotels and

schools. . . . A lot of work has been conducted to help HIV/AIDS-infected children to be admitted by universities. However, they will not be employed as teachers, medical doctors, or government officials after graduation because of their positive status." Infected individuals anticipate discrimination in health service provision; doctors in general hospitals refuse to operate on HIV/AIDS-infected patients. The university professor in Beijing again revealed, "HIV/AIDS-infected individuals can receive operations in only two hospitals in China; both of these are located in Beijing. A local doctor in Chongqing told an HIV-positive patient that he should take a train to Beijing in order to receive operations."

In line with the global HIV/AIDS-security practice (i.e., increasing the engagement of civil society in global HIV/AIDS responses), Chinese leaders have repeatedly acknowledged the importance of the role of HIV/AIDS-related NGOs in national policy implementation since 2004. Having said that, the HIV/AIDS-related "third sector" development is nevertheless restrictive in scope. Explaining the relationship between the authorities and NGOs, a university professor in Beijing suggested: "In normal circumstances, local CDC staff hand over treatment delivery work to community-based organizations. Nonetheless, CDC officials intend to keep these CBOs small, giving them just enough money to run the programs, so that they wouldn't grow too strong to pose potential threats to the government. . . . These CBOs are usually very small, operated by one or two people, on a part-time basis." An HIV/AIDS specialist working in an international NGO in Beijing further stated, "During a 2011 HIV/AIDS NGO meeting, the Chinese government clearly claimed that the authorities would like to work with NGOs/CBOs conducting service delivery, but not with those working on HIV/AIDS-related human rights or gender issues." Considering the nature of NGOs and CBOs working on HIV/AIDS, service providers are preferred by the state, whereas groups serving as advocates of human rights and agencies providing legal services for HIV/AIDS-infected people would be subjected to prosecution and coercion. To illustrate this point, Chinese leaders publicly praised a Guangxi-based NGO named AIDS Care China, recognizing the work the organization had done in HIV/AIDS prevention. Meanwhile, an HIV/AIDS-related legal aid NGO, Beijing Yirenping Centre, was raided, and two of its activists were detained in June 2015. In this regard, the continuous inclusion/exclusion process would weaken HIV/AIDS advocacy groups that were conceived as threats to the legitimacy of the authoritarian regime while preserving NGOs and CBOs that are willing to be under control by the state apparatus and prepared to accept the regime's policy measures.

Eric A. Stanley: If we are to take as a point of departure that AIDS is globalization, then the two questions that, for me, follow are: How is HIV/AIDS written through globalized racial capitalism; and related, what is the relationship between colonization and HIV/AIDS? These questions are far too large for me to begin to answer here, but in the US context I'm thinking back to the CDC's 4Hs (hemophiliacs, heroin users, homosexuals, and Haitians) that signified the real and imagined "high-risk" groups of people living and dying in the early 1980s. This marker of Haiti as vector cannot be divorced from the ways the white state (especially the United States and France, who both have a colonial and para-colonial relationship with Haiti and were doing much of the early publishing on the pandemic) has produced Haiti, by way of spectacle and exclusion, as always in need of punishment for its original and founding sin of decolonization. In other words, that Haiti was born from the first successful slave revolt in the Western Hemisphere, a success that then placed, and now continues to place, into jeopardy US exceptionalism, cannot be overlooked. This is a point made by many Haitian activist/scholars, but I am returning to it here because it seems important to understand how the epidemiological foundations of what we have come to know as "HIV/AIDS" are the haunts of conquest and chattel slavery.

This white fantasy of the unruly Black body, which is to say the fantasy of the US unconscious echoed through the Haitian narrative, is again reverberated through the attention paid to HIV infection rates in Black communities in the United States. There seems to be never-ending streams of money to study, chart, graph and report on HIV and Black communities, and yet the structured abandonment, which is among the mechanisms of racial capitalism, ensures the tools necessary to support Black HIV-positive people and slow new infection rates are always missing. Perhaps this point is too obvious, but nonetheless, when we think "globalization" we must attend to the histories and futures of forced movement (enslavement, migration, genocidal depopulation and repopulation). Or, one way we might think about the globalization of AIDS is by looking at uranium mining on the Navajo reservation, or gentrification in Fruitvale, California. How might we think, which is say how might we respond to HIV/AIDS differently, if these were among the places we began questions of globalized AIDS?

This is not to suggest a kind of US centrism, but what I'm interested in is thinking deep situatedness alongside geopolitics. For those of us primarily based in what is sometimes called "the West," the move toward thinking the globe too often leads us to seeing the processes of extraction and constriction in geographies far away. Among our challenges, as those who differently

inherit the spoils of empire, is to work collectively to grapple with these thick histories so that connections of depth might be made through locations and not simply over them.

Ian Bradley-Perrin: When thinking about the local and global of HIV/AIDS, I cannot help but consider how the pharmaceutical industry seamlessly inhabits these juxtaposed frames for the epidemic. At the local scale, pharmaceuticals are ever present. They are the daily personal reminder of difference for the positive person with access to medication, and they are the local struggle of access and adherence that culturally and socially define difference among positive people. At the global scale, they define globalized capital. The trials that validate a pharmaceutical's efficacy are funded from high-income, high-cultural-capital centers and they are administered and undertaken in impoverished areas. The global and the local of pharmaceuticals are always embedding themselves in one another as well. The money made from the drugs that successfully pass these trials is invested in community projects, like Pride Parades and AIDS Service Organizations. These spaces then serve as recruiting grounds for further trials and target markets for the products they produce. Pharmaceuticals hold local power through their biological necessity and fear of their absence and mobilize global power through the capital they acquire through local centers as numerous as the populations they serve, growing every day through perpetual market expansion.

PrEP (preexposure prophylaxis) is a striking example of this phenomenon. In *Drugs for Life*, Joseph Dumit proposes that we have entered a new biomedical paradigm. The previous paradigm understood the body as essentially healthy, with intermittent medical intervention to return to that natural state. Dumit claims we have entered a new medical conception of the body as essentially ill, requiring medical intervention to stave off our natural state as diseased. If asked, most would say that disease is symptomatic (real and experienced). However, the new paradigm approaches disease as the risk of becoming symptomatic (and if we paused, most could clearly see this playing out in our lives). The efficacy of interventions in the new paradigm is determined by randomized control trials, and these trials, which require huge subject participation and capital investment, are undertaken either by the pharmaceutical industry or with funding from them. This produces a system of disease identification and remedy that is not accountable to the public but only to shareholders.

The risk paradigm expands markets and creates new ones. Since disease is no longer defined solely as symptomatic, the pharmaceutical industry is

positioned to create new consumers for products whose necessity is defined by the very trials they undertake to determine the efficacy of their products. Everyone is a consumer in a world where everyone is at risk.

In January 2016, AIDS Healthcare Foundation (AHF) brought a formal Food and Drug Administration (FDA) complaint against Gilead for promoting the situational use of Truvada when the drug is only approved for daily use. The complaint centers on an ad called "I Like to Party." Of the complaint, Michael Weinstein said: "Gilead, which we believe has been deliberately mounting an under-the-FDA-radar, guerilla-style marketing and media campaign for PrEP for the past three years by funding scores of community and AIDS groups across the nation to promote PrEP, has run afoul of the FDA by funding this ad promoting off-label use of PrEP."[10]

Responding to this, *The Advocate*'s Tyler Curry wrote in January:

> Gilead had no part in the creation or development of the advertisement or any other PrEP advertisement by an independent organization. To date, Gilead has yet to release a single ad for PrEP. Instead, the drug company has left it up to HIV service organizations to educate those at-risk for HIV about the benefits that the prevention strategy has to offer. The movement to spread awareness has been an uphill battle, primarily because Weinstein, via AHF, has spent thousands buying ad space in local publications, shaming those who would use the prevention drug, purporting false claims of dangerous side effects, and calling Truvada, in its revolutionary HIV prevention use, a mere "party drug."[11]

I am no great lover of AHF or Michael Weinstein. They are repeatedly and correctly accused of using fear and stigma to promote their brand and using the weight of the law to diminish or destroy smaller dissenting voices in their market. But I find the exchange here regarding the cultural construction of PrEP enlightening.

First, PrEP does need to be taken daily. The IPreX study results, published in the *New England Journal of Medicine* on December 30, 2010, found that there was a 44 percent reduction in HIV infections among those randomized to Truvada rather than the placebo. The 90 percent-plus figure we bandy about is the product of a case control study within the IPreX, which demonstrated that those who did seroconvert despite being randomized to Truvada were not adhering to their medication. Thus the FDA complaint addresses this gap between the corrected results of the RTC (randomized control trial) study and the results of the case control study.

Second, AHF is described by Curry as an obstacle to "the movement." Gilead and its product Truvada are characterized as a movement, likening them to previous health movements such as the women's health movement and AIDS activism. Weinstein is characterized as obstructive. This is not unusual. The medical establishment has long been the target of health movements. But AHF is a HIV/AIDS community clinic, something that AIDS activism desired. Given that Weinstein's trajectory is one not of activism but rather of professionalization, he took an approach to HIV/AIDS not unlike that taken by many advocates and activists as AIDS service became professionalized and bureaucratized. Curry alleges that AHF's $1.1 billion budget is thrown behind its obstruction of the movement, but this characterization of Gilead as the movement and AHF as the obstruction is a false dichotomy.

Gilead is not a person (except in the corporate sense); nor is it a movement. Founded in 1987, Gilead immediately recruited Donald Rumsfeld to the board of directors, as well as Harold Varmus, who later became the head of the National Institutes of Health (NIH). These powerful connections have been essential to the rise of Gilead's profits. As reported by Dr. Joseph Mercola, when George W. Bush demanded in 2004 that the US Congress pass $7.1 billion in emergency funding to prepare for the possible bird flu pandemic, $1 billion of this funding was to be allocated solely to the purchase of Tamiflu, a patent owned by Gilead. Rumsfeld, who prior to his role as secretary of defense had risen to chairman of the board, retained his stocks despite his appointment and profited $12 million from Tamiflu.

Gilead again came under intense criticism from ACT UP Paris in 2004 when activists stormed the stage of the International AIDS Conference holding signs claiming that Gilead "uses sex workers for free." The protesters argued that nine hundred HIV-negative "beer girls," working the bars of Phnom Penh, were recruited for a placebo study (which is illegal for HIV in the United States since the standard of treatment is much higher).

The early PrEP trials received much less attention. However, Kirsten Petersen argued, in a paper given at the Second International Conference for the Social Sciences and Humanities in HIV, that the trials on HIV-negative women in Nigeria were facilitated by the military intervention of the United States, which displaced Nigerian communities off oil-rich land, destabilizing these communities. These same communities were then identified as being at high risk for HIV due to their violently reconfigured social structures produced by displacement and were proposed as the ideal site for PrEP trials. Peterson argues that US Africa Command (AFRICOM) and the United States President's Emergency Plan for AIDS Relief (PEPFAR), both controlled and established by

Bush and Rumsfeld, tied together US foreign health policy with military policy to the benefit of, among others, Gilead Sciences. With these connections and power, it is unsurprising that Gilead is currently valued at $32.4 billion with $27 billion of revenue a year, dwarfing AHF's $1.1 billion.[12]

Weinstein's claim that Gilead is engaged in "under-the-FDA-radar, guerilla-style marketing" is not addressed by Curry; instead, Curry states that Gilead is not to blame in the situational promotion of PrEP because Gilead has not produced any advertisements for the drug but provides unrestricted funds as part of a comprehensive prevention strategy. They are saying the same thing. PrEP is not advertised by Gilead but the marketing of PrEP has relied on hundreds of NGOs using Gilead's unrestricted funds to promote the drug within a community framework. A perfect example is the Stigma Project, which is a marketing- and advertising-oriented website, producing flashy visuals to counter the stigma of HIV. The website has an entire section devoted to PrEP as well as having it integrated into the project's other campaigns. Gilead cannot be at fault for the misleading situational dosage recommendations because it has designed a marketing strategy that intentionally divests it of that responsibility. Through the funding of these various organizations, PrEP is marketed to our community by our community. And by a clever sleight of hand, Gilead becomes the éminence grise while we "speak for ourselves," using "unrestricted" funds. And as a side note: the provision of the costly drug for free in exchange for trial enrollment is a marketing tactic, as it both verifies its efficacy to a consumer public and expands the market for the product, producing consumers who will have to purchase the medication when the trial ends.

These campaigns adopt the risk-based understanding of disease, and identification with this risk becomes the consumer drive to acquire the product. The mainstream media coverage is revealing of how the dominant culture interprets the PrEP phenomenon. A great example of this is the *New York Magazine* article "Sex without Fear," in which the implicit point is that "before we were afraid of sex with HIV+ people and now we are not." PrEP does nothing to reduce the legal burdens on poz people and does not mitigate the nondisclosure laws, thus the reduction of fear is a one-sided process. Because HIV stigma drives this product, at its very core, it *is* the product. The fear that we could become that which we define ourselves against is the fundamental motivation to take preventative medications. Under the claims that sex negativity and HIV stigma prevent HIV-negative people from accessing PrEP is the mobilization of stigma to create new markets and consumers for commodities that respond to this fear. The promise of a newly guaranteed future is marketed and consumed by our community, for our community. But it is not owned by our community.

In the words of Sarah Schulman, "It normalizes the fact of people's lives without actually addressing any of their special needs."[13]

Theodore (Ted) Kerr: As the historicization of HIV started to increase in the second decade of the twenty-first century, I found myself looking for a structure of thinking, feeling, and believing to better understand the virus, its impacts, and its history. This, in part, led me to attend seminary, where I studied Christian ethics. I wanted tools to see HIV not only as a twentieth-century event but as a longer moment. Informing my education was liberation theology, a belief system rooted in the idea that God is always with the oppressed, and that the material and contextual matter.

As a white, cis, HIV-negative gay guy from Canada living in the United States, working at the intersection of culture, AIDS, and activism for the last fifteen years, I began thinking more about the virus as its own thing, considering the global moves HIV has made through space and time. It's this I want to bring to our dispatches, specifically the when, where, and ideas of how HIV went from a localized virus to a worldwide pandemic, and what questions thinking about the long moment of AIDS bring up in thinking about how to respond and map the ongoing epidemic.

THE WHEN: The oldest HIV-positive sample we currently know of comes from a sample of blood plasma from a Bantu man who lived in Leopoldville in 1959. When this sample was sequenced by scientists in 1998, they discovered HIV had been circulating longer than previously thought, maybe as early as the 1930s. Ten years later, sitting on a laboratory shelf, the second-oldest HIV sample was found: a paraffin-saved biopsy of a lymph node from a woman living in 1960 who, like the man from 1959, had also been living in Leopoldville. This led to a whole new timeline.

Like you can learn the age of a tree by observing the cross-section of a trunk and counting the rings, you can learn the age of a virus by charting its mutations. After HIV has entered the body, latched onto a cell, replication of the virus begins through recombination. This is where mutation occurs, and HIV's high genetic variability becomes important. The reproduction of HIV never results in a perfect replica, so the longer the virus has been around, the more recombinations there will have been. In sequencing the 1960 sample and then comparing it with the 1959 sequenced sample, scientists were able to determine that people have been living with HIV even earlier still: since around the late 1890s—give or take a decade.

THE WHERE: To determine where HIV began, more comparing would be needed, this time looking at sequences of Simian Immunodeficiency Virus

(SIV), HIV's nearest zoological neighbor—the idea being the location where they find chimps living with a strand of SIV that most closely matches HIV will be the home of HIV or at least be a point in the right direction.

By now it is accepted that HIV is a result of spillover, a term to describe what happens when a virus spills over from what we may call an animal to what we may call a human. Through a series of studies with samples from captive chimps, a research team was able to establish that the closest SIV/HIV match came from a subspecies of chimpanzee that live only in western Central Africa—already a narrowing down of possible locations. To get more specific, researchers went into the field using noninvasive techniques to gather more samples of SIV from the chimps. What they found was, just like HIV is not evenly distributed across the world, neither is SIV. And in fact, the area where there were the highest rates of SIV was also where SIV and HIV most closely matched: the Southeast corner of Cameroon, now accepted within scientific communities as the cradle of HIV.

THE HOW: The most common theory is that the fateful spillover occurred during routine chimp hunting, a messy affair in which the blood of the prey and of the hunter comingle though struggle. At first, HIV stayed local and seemingly unnoticed within a contained community in rural Cameroon, with a replication rate most likely of 1.0—meaning one person passed it on only to one person. After the first few decades of the virus's slow circulation in Cameroon, HIV traveled south, via folks moving to urban centers such as Leopoldville, where by the end of the 1950s the virus had already been circulating long enough and at a heightened replication rate that remarkable recombinations had been made.

By then the capital city, founded less than fifty years earlier, was a thriving African metropolis amid much upheaval. In 1960 what had been the Belgian Congo achieved independence from Belgium, being renamed the Republic of Congo under the leadership of Patrice Lumumba. Within five years, Lumumba was dead, Joseph-Désiré Mobutu was in power, and Leopoldville was renamed Kinshasa, part of Mobutu's Africanization efforts. Amid the upheaval, European nationals were sent packing. But since the colonial leaders had withheld education from the natives of the country, world powers working with leaders from the Republic came in and peopled the country with doctors, teachers, and other professionals from Haiti.

Within a similar life span of HIV, Kinshasa went from a small colonial trading post to an African capital with direct links to the rest of the world, a place overcrowded, thick with political tension and too many men, and ever changing due to shifting social—and therefore sexual—norms. Within all

this, HIV was being shared, causing death, and at a quickening pace moving far beyond where it came from.

AIDS in the United States: We don't know yet how HIV came to the United States. We do know that HIV was circulating in the United States as early as the late 1960s. The life and death of Robert Rayford, a Black teenager who died of AIDS-related causes in 1969 in St. Louis—confirmed in 1988 in the *Journal of American Medicine*—shows us this. This is further supported by an article published in the October 2016 issue of *Nature* that states HIV can be seen within sexual networks in New York as early as 1970.[14] And like its first few decades in Cameroon, HIV's first few years in the United States were probably marked with a relatively low reproduction rate, slowly increasing over time as it began to ingratiate itself in situations where bodily fluids are more readily shared: sexual encounters, intravenous drug use, and medical procedures.

The epidemic as we know it now was not discovered until rare illnesses started appearing in young white gay men's bodies in New York, Los Angeles, and San Francisco in the early 1980s. From here the story becomes familiar: if the majority of the men showing up to doctors' offices had been straight, it is clear there never would have been an epidemic. But instead the Ronald Reagan administration reacted with apathy and inaction, and so a plague befell the nation, stemming from a virus that had already traveled the world. In response, people living with the virus, those who loved them, and those who could not stand idly by stepped up.

When we talk about AIDS history, it often leads back to this moment in the early 1980s in the United States, and the urgencies of that time. But everything before this moment gets lost. I wonder what histories could be uncovered, what actions could be taken, and what discussions could be had if we also took a longer approach to AIDS history?

An Introduction to Church History class I took at seminary began with the question: How did a religion started as a cult of outsiders in the Middle East come to be so closely associated with dominance and white supremacy within the southern United States? In hearing the question, I wondered a similar thing: How has a virus that began in a southeast corner of Cameroon possibly as early as the late nineteenth century come to be so closely associated with white gay men living on the coasts of the United States in the late twentieth century?

Walking away from that class with my own experiences in mind, my first answer to both seems similar, clear, and possibly worthy of further discussion at our table: war, colonialism, and, yes, globalization, along with all the white supremacy, homophobia, and patriarchy that comes with all three.

Prompt 2

Shahani: Taken collectively, your responses foreground the different spatial and temporal forms that AIDS globalization has taken in the past, and how newer manifestations of these forms continue to fatally inform our present and future. These "thick histories" (Stanley) of global AIDS, as your responses have pointed out, operate through the local and global pathologization of Black bodies, through the genocidal nexus of bio- and necropolitics, via the state regulation of dissent, through the recycling of colonial violence, through the multinational pharmaceutical corporations' mediation of drug access and the championing of market logics, and through the control of bodies via their enforced movement and/or the policing of social and national boundaries. Furthermore, despite the "end of the nation" narratives that often accompany globalization's seeming challenge to discrete state sovereignty, your responses usefully highlight the renewed and specific roles that nation-states have played in refusing health care and accountability to people living with HIV and AIDS (the former Soviet Union, China, the United States); they also foreground how the Africanization of AIDS or the use of nations in the Global South as sites for clinical trials recentralize the nation-state even amid globalization's supposed abrading of national paradigms.

If, as your responses have emphatically suggested, global capitalism cannot "get AIDS out of our lives" (Schulman), what modes of political, aesthetic, cultural, or activist resistance can we locate to challenge the insistence that global capitalism is the cure? What are the constraints that inform these challenges? Your responses can draw on the past or elaborate on more contemporary modes of resistance to global AIDS.

Schulman: Ian Bradley-Perrin analyzed a year of HIV coverage in the *New York Times* and noted that the vast majority of the articles were about PrEP. Now, as a wizened observer of the media machine, I know that every article that appears in the *Times* has a vast apparatus of lobbying behind it, and that this slanted focus reveals the hard work of Gilead—a company whose name evokes a long history of promised Protestant utopias. The irony here, of course, is that the massive and endless market for PrEP is a consequence of the commodification of health care in the United States. And as the Trump regime deprives even more of us of our already inadequate coverage, I predict a rise in profits for PrEP. And this model of profitability is the global example, since much international care and prevention is funded by, and therefore controlled by, Western pharmaceuticals and governments.

While I support people using PrEP, its profitability is based on fear of HIV infection. Pre-Trump, with 20 million people added to the realm of vague health insurance under the highly dysfunctional, expensive, but existent Obamacare, we approximated that only one-third of HIV-positive Americans were receiving the standard of care. This leaves approximately two-thirds of HIV-positive Americans in some realm of infectiousness. Since global trends in HIV criminalization reflect and promote an international transformation in ideology of HIV negatives from "people responsible to keep themselves negative" to "people who are potentially criminally wronged," feeding the never-ending stigma around HIV is at an all-time high. Of course, if all citizens of planet Earth had adequate health care, and were all at the current standard of existing care, very few would actually be infectious. If the overwhelming majority of HIV-positive people were allowed to access existing treatments, suppressed viral load would be the norm. In this way, not only would fewer new infections take place but the psychological demand for PrEP would cease. In this way, the enormous market for PrEP is dependent on the general perception that people with HIV are overwhelmingly infectious. And this perception is dependent on HIV-positive people not getting existing medications so that this perception persists.

When Jim Hubbard and I went literally around the world with our film *United in Anger: A History of ACT UP*, the absolutely worst conditions that we encountered were in Russia. We arrived just a few weeks after the inauguration of the new antigay laws, and the arrests of Pussy Riot, signifying a coalition between Russian state and Russian church to degrade women and homosexuals. In Russia we found separate organizations for gay people with HIV and for straight people with HIV, since most infected people there are former or current needle users. The distribution of medications was in disarray because all medicines in Russia are ordered by a government office, and this office was not up to date on HIV medication. So while my friends in New York were taking Quad, a compound, we met people in Russia taking seven to fifteen pills per day. Women with HIV were desperate to get Truvada, so that they could prevent transmission prenatally to their children, but their government wasn't ordering it. A subsequent visit to Taiwan revealed similarly uninformed government ministers making bad policy, where uneducated health authorities essentially outlawed poz-on-poz sex, forcing infected people to avoid the state-run health system altogether in order to avoid detection and surveillance.

Juxtaposing the US example and the Russian example and the Taiwanese example, we see that greed and ignorance serve as doppelgangers in

the hands of authorities: be they corporate or governmental, using people with HIV and keeping them untreated and infectious as means to their own power.

Lo: In the Chinese context, early representations of AIDS (in the 1980s) framed the epidemic as a "capitalist disease." Locals played around with the Chinese name of AIDS (愛滋病, *aizibing*), changing the middle character to become (愛資病, *aizibing*), for the two middle Chinese characters are homophones. The latter name literally meant "love capitalism disease," implying that HIV/AIDS was the consequence of favoring Western liberalism and capitalism over socialism. In other words, resisting capitalist influence for a socialist country was believed to be the way to stop HIV/AIDS entering and spreading in the country. After the HIV/AIDS outbreak among injection drug users in Yunnan province in 1989, Chinese authorities responded by criminalizing drug use and drug trafficking, and prohibited positive individuals from entering the country. Furthermore, the 1989 "Law of Infectious Diseases Prevention and Control" required HIV/AIDS-infected individuals to be quarantined, with their names and addresses reported to the government.

Despite the prevailing advocacy of HIV/AIDS interventions in an integrative manner in the international community and national governments, there has been a consistent push to maintain the exceptional status of HIV/AIDS as a unique health challenge in China. A program manager of a HIV/AIDS-related NGO in Beijing commented, "NGOs believe that a stand-alone approach is more suitable for HIV/AIDS responses owing to severe stigma problems in China. Infected individuals cannot receive treatment in normal health care settings due to their positive status." Similarly, a CDC official in Zhejiang province stated in 2017, "I believe a stand-alone program is more suitable for HIV/AIDS interventions in China. An integrated approach is more suitable in countries or societies with less HIV/AIDS stigma. HIV-positive individuals in China go to specialized hospitals for treatments; doctors working in these hospitals have trained to treat HIV/AIDS patients." That HIV/AIDS stigma and discrimination can lead to human rights violations has been highlighted in the 1998 *International Guidelines for HIV/AIDS and Human Rights*, advocating for positive and rights-based responses to HIV/AIDS. However, in an authoritarian state where individuals cannot ask for treatments on the basis of personal and human rights, AIDS exceptionalism has become a means to mitigate stigma and discrimination attached to HIV/AIDS without directly addressing or improving human rights situations in China.

Numerous HIV/AIDS activists have been suppressed through imprisonment, house arrest, or assault in the past years. Dr. Wan Yanhai and Dr. Gao Yaojie were two prominent Chinese HIV/AIDS activists who fled to the United States in 2009 and 2010, respectively, due to pressure and harassment by the Chinese authorities. A graduate of Shanghai Medical University in 1998, Wan was the former health education officer in the Ministry of Health. Despite working in the state apparatus, he was dedicated to advocating for the rights of homosexuals and sex workers to receive HIV/AIDS-related treatments. He was arrested and interrogated for leaking state secrets in 2002 since he exposed an internal official document related to the outbreak of the epidemic caused by private blood banks in Henan province. Following his release after widespread international condemnation of his secret detention, Wan continued to address HIV/AIDS in China through the establishment of the Beijing Aizhixing Institute on Health and Education (also called Love Knowledge Action in English) in the same year, advocating for the rights of queer populations, and providing financial and technical support for other small-scale community-based organizations working on HIV/AIDS in the country. A director of an NGO in Beijing recalled the impact of Wan's departure during an interview in 2011: "The director of Love Knowledge Action is the one who helps us write the financial report for the submission to the Global Fund. We can no longer apply for the Global Fund grants after he left China."

Another figure who made a significant impact on AIDS activism in China was Dr. Gao Yaojie, a retired Chinese gynecologist who first discovered HIV/AIDS in Henan in 1996 while treating a female patient infected with HIV/AIDS via blood transfusion in a local hospital. Since then, Gao has devoted her entire life to HIV/AIDS education and prevention work, giving free treatments to people infected with HIV/AIDS in villages of Henan before the implementation of the "Four Free One Care" policy in China in 2004. Her dedication to HIV/AIDS interventions has profoundly raised the public awareness of HIV/AIDS but at the same time exposed the provincial government-initiated plasma selling in Henan. To cover its mismanagement and malpractice, the local government bribed the infected villagers and farmers. Activists like Gao who were engaging in disclosing the official malpractices were harassed and imprisoned. Henan officials blocked reporters from the China Central Television (CCTV) and *The People's Daily* (a widely circulated Chinese newspaper) who wanted to interview Gao. Monitored by more than fifty cops, three police cars, and numerous journalists, Gao was prevented from having any engagement with the rest of the world and was blocked from leaving China to receive a human rights award in the United

States. Gao was placed under house arrest in February 2007, but her work on HIV/AIDS awareness has acquired visibility and created awareness. Based on the 10,001 letters written by infected individuals and their family members between 1996 and 2004, she published the renowned book *China Plague: 10,000 Letters* with a Hong Kong publisher in December 2009, documenting the unhygienic plasma collection/selling in the black market as well as how HIV/AIDS remained rampant in several Henan villages.

Stanley: It seems we have an avalanche of data and evidence that the state (in its various iterations) is well equipped to deliver death, even under a regime, as Foucault might have it, most concerned with the management of life. To this end, the continued reliance on the state as that which will end, or at least diminish, the brutality of the pandemic traps us in a feedback loop while the body count climbs. Perhaps it is a simple answer, but I would say the last twenty years of HIV/AIDS "work" has primarily been focused on disenfranchising people most directly impacted from transforming the terrain of their lives. This takes many forms, including the more quotidian NGO/nonprofitization of HIV/AIDS, to the more spectacularly brutal forms of incarceration and militarization of communities, mostly of color, in the United States and globally.

I do believe that many people providing direct support are vital in the struggle against HIV/AIDS: for example, people working to create and/or expand syringe exchange programs, and people working on housing and food security. Yet here I am attempting to suggest a structural analysis that sees HIV/AIDS as contingent on racial capitalism. The question then is not if work against HIV/AIDS should include a critique of accumulation and extraction but what forms an anticapitalist HIV/AIDS activism/study might take.

To this end, there is radical work being done to think about, for example, the connection between HIV and settler colonization. One artist growing this conversation is Demian DinéYazhi, a Diné transdisciplinary artist/activist from New Mexico, who is currently living and working in Portland, Oregon. His work also helps us know that the "United States" is an imagined project, maintained through brutal force, that is, the attempted confinement and liquidation of hundreds if not thousands of native nations. One of his graphic works is "POZ since 1492," which, through a reassemblage of visual temporality, reads conquest through and beyond the virus.

Along with artistic production like DinéYazhi's, I am also deeply inspired by localized and often unfunded movements that are working against HIV criminalization in Canada and the United States. This is another space

where prison abolition, disability justice, and HIV/AIDS activism are cross-pollinating our movements, making them sharper and hopefully more forceful.

This is perhaps a long way of saying that I think supporting direct action and mutual aid, centered on those most affected, is the best, and perhaps only, way of confronting the ravages of racial global capitalism, of which the pharmaceutical industry is a major player. Yet what I don't think we need is a nostalgic "return" to ACT UP that produces HIV/AIDS only in the past tense. To place AIDS as a relic of history, something to be known only through backward glances, is a deadly erasure of both our current moment and the future of HIV/AIDS.

I think history's power is transformative when written through our current moment in an attempt to imagine more radical and liberatory futures. While much of what ACT UP did was central to many of our political educations (myself included), direct action must be a methodology and not simply a series of events. This "direct action as methodology," I think, creates cultures of resistance as an ongoing practice and the precondition of social life for those held against the wall of normative power.

To be clear, I do believe we need continued and expanded confrontational street-based direct actions that disrupt, to the point of collapse, the smooth space of everyday destruction. I also think we need to imagine what working with those in the hard sciences who have the skills to reverse engineer necessary medications as well as conduct research might look like. Perhaps this is a dreaming project, but I think we must still demand, which is to say build, an anticapitalist science and pharmaceutical underground that understands collective freedom and not individual profit as that which guides it.

Kerr: In order to respond to the prompt, I need to give some context, some background on how I see the history of the AIDS response, and then what I see emerging as what we may call resistance.

A few years ago everything was coming up doula. The Radical Doula blog was growing in popularity; people I knew were starting to work more as abortion and death doulas, and colleges were starting gender doula programs to support students through the process of asserting their gender in school. Amid all this I started to wonder: Is there a role for doulas within the ongoing response to HIV?

Around this time, I had the chance to create a one-day think tank about contemporary HIV issues. I took the opportunity to program a roundtable titled "What Would an HIV Doula Do?" To respond I invited Lodz Joseph,

a birth doula who has done AIDS work in Haiti; Michael Crumpler, a friend from seminary who was in his final stages of becoming a chaplain; along with other peers I admired from the world of art, literature, activism, and health care.

Lodz, along with practicing end-of-life doula iele paloumpis, explained to the group what a doula did. While the idea of a doula goes back to ancient Greece and relates to the work of a handmaiden centuries later, foundational to doula work, explained Lodz, is holding space. This can mean anything from having ice chips ready for a dry mouth, to knowing when to call a doctor, to supporting someone as they advocate for themselves in the hospital. For Lodz, who works in Brooklyn, much of the power of a doula comes from performing the mundane. She sees how folks can get caught up in worthy complex global health work yet how often this means they miss basic and overlooked life-saving interventions that can happen within one's own community. As Lodz shared, it's not an either/or situation but an invitation to see what is hiding in plain sight.

Upon hearing Lodz share her thoughts, Michael, in a substance recovery program, living with HIV, with a busy church life, pointed out that there are parallels between doula work and the labor of an AA sponsor, a chaplain, and a trusted friend: all are people in your life who can remind you of who you are in the aftermath of trauma, helping you connect to the innate knowledge you possess as you transition toward possible sobriety, a higher power, or living with HIV. While he and others in the think tank have experience with case workers, buddy systems, and mentors, he saw the possible role of an HIV doula as different from these preexisting supports. Others, like myself, agreed.

Helping us think through the differences, Tamara Oyola-Santiago, having worked in needle exchange, student health, and with various AIDS service organizations in Puerto Rico and the United States, invited us to keep the individual in mind while also considering what an HIV doula would do on a systemic level. As she pointed out, it isn't just people who transition in the face of HIV; so too do institutions. For example, many AIDS Service Organizations (ASOs) started off as small groups of people brought together to address the suffering and death of their friends, with many now large multinational service providers, administrators between "clients" and the state. At the root of Tamara's point was, How do we *doula the system* to create the institutions we need and want? I found this line of questioning helpful because it aided me in seeing how the doula work fit into my thinking around the shifts within the HIV response.

The earliest reactions to the epidemic were from those dying and their intimates. It was friends, lovers, and strangers within the struggle, aiding people as they died, holding space for the living, and demanding action from an apathetic public and murderously silent governments. As the 1980s bled into the 1990s, rates of HIV and death increased, and bonds of response replicated and reformed, creating communities upon communities built on mutuality and care. An awareness emerged: the virus is shared within community, no one gets HIV alone, and so the response should be rooted in relationships.

Eventually, though, with the release of protease inhibitors in the late 1990s, things changed. Management of the crisis became more medicalized, thus professionalized. AIDS went from public to private amid the globalized epidemic. Systems of pharmaceutical distribution were introduced and scaled up around the world, administered in no small part—as Tamara was saying—by ASOs. This, of course, saved and improved millions of lives, and should never be downplayed or taken for granted—and is a task still being worked out as around 40 percent of the global population living with HIV still doesn't have access to medication.

At the same time highly active antiretroviral therapy (HAART) was being prescribed around the world, small-scale community responses in North America (and I am sure elsewhere) quickly became hard to find, having disbanded in localized triumph, dwindled due to loss of funding and attendance, or disappeared altogether. In everyday life for people living with HIV in the United States, bonds that had formed out of a shared relationship to death thinned in the face of divergent realities around survival.

For people with insurance, stable housing, and individualized support, HIV can be a manageable chronic illness, a situation between patient and doctor. For people who have been minoritized and are without economic stability, HIV exacerbates preexisting crises, which often are dealt with less by friends and lovers and more by social workers, and increasingly by the criminal justice system. In these experiences, there is no privacy in living with HIV, but the process of dealing with HIV has largely been privatized. Large multinational foundations such as those started by the Bills (Clinton and Gates) compete with nation-states to auction off the work of HIV to for-profit and nonprofit agencies. Due to the enormity of the ongoing crisis, the intimate ways of dealing with HIV are gone. But what is the impact of how they have been replaced? For some people living in the United States, long term with HIV, meeting up with friends at weekly activist meetings is a memory now replaced with sitting in alienating waiting rooms, living in

state-subsidized housing in gentrified neighborhoods feeling like a pariah. For those who seroconverted after the release of HAART, the shifted HIV landscape is keenly felt. A cultural history informs them that for some, a diagnosis once came with a rallying community. With AIDS in the twenty-first century, this is not the norm. The promise of medication with a positive test result comes instead with ever-present stigma, renewed public ignorance, a sense of isolation, and increased surveillance. Amid this shift, the thick trust that once ensured that the HIV response was being done in the best interest of those living with the virus has been upended. The response is now more beholden to nefarious tenants of public health, notably, the containment and monitoring of people living with communicable diseases for the peace of mind of the worried well. Gone are the days where a person's T-cells were measured to keep track of a person's health; now viral load is monitored to track pill adherence and transmission rates.

And this is where my response to the second prompt comes in: amid the privatizing shifts within the AIDS response has also been a long legacy of community organizations that have remained connected to the grassroots in their work, for example groups like AIDS Action Now in Toronto, and VOCAL NYC and Visual AIDS in New York. Joining these groups, and inspired by them, is our What Would an HIV Doula Do? collective.

Progressing from a one-time round-table conversation to a collective that now holds open monthly meetings, hosts events, and partners on programming with other organizations, our work is an intervention into the globalized and privatized climate of AIDS. We are building—with others—a critical mass of community into the AIDS response. We are building thick bonds to replace those that have been thinned. We see ourselves as creating new opportunities and supporting preexisting ones for people living with HIV and those deeply impacted to be in community together around the virus, along with those who are new to the conversation. Through writing, direct action, conversation, art making, and other strategies, we are dragging forward lost conversations and actions around HIV/AIDS, creating spaces for people to share private thoughts and experiences around the virus, and helping people to be less afraid and more proactive. This is what we mean by holding space.

Crucial to our work is questioning how testing is done, abolishing HIV criminalization, pushing back against the whitewashing historicization of the crisis, and responding to whatever comes up within the collective. In this work, we consider how medical, professionalized, and global responses are to be included, working toward having those forces respond

to the needs, wants, and demands of HIV-centric communities rather than the other way around. This is what we mean by doula-ing the system, and an answer to what does resistance in the face of a globalized AIDS response look like.

Bradley-Perrin: Many of the responses above point toward the intersection of nation and epidemic. The politics of AIDS for much of the first two centuries was played out politically in these arenas. Schulman's early account of AIDS in the Soviet Union resonates with an ongoing silence in former Soviet states and particularly Russia on the expansion of the epidemic into the present day, and Lo's analysis of AIDS in the current Chinese state. And both Stanley and Kerr have written about the social impacts of racial constructions at the national and international level through history. While historically useful in understanding early political responses, national AIDS politics has always played out on an international stage as a social, economic, and political crisis. These dispatches from our brilliant respondents point toward the history of AIDS as a global political phenomenon. While deeply embedded in national policy, AIDS, from its epidemiological trajectory to its economic network to its political responses, has been for four decades and beyond a fundamental part of international politics, global governance, and transnational resistance. I want to think about two classic texts, one historical and one theoretical: Warren Montag's "Necro-Economics: Adam Smith and Death in the Life of the Universal" and Timothy Haskell's "Capitalism and the Origins of the Humanitarian Sensibility." The first historicizes new economic and cognitive patterns and the second questions the countervailing forces that operate against that new cognition from within that new system.

Montag reads Adam Smith's *The Wealth of Nations* through a biopolitical lens and demonstrates Smith's market system operating on the premise of government-sanctioned death. He states, "The subsistence of a population may, and does in specific circumstances, require the death of a significant number of individuals: to be precise it requires that they be allowed to die so that others may live."[15] Different from the execution, this is a death through forced exposure. The government, in Smith's model, must only intervene to prevent the masses from overtaking the food stores in a famine, in order to allow the market to correct its natural dearth. This return to equilibrium is only achieved through the sacrifice of elements of the population in the name of order: "It is here that the sovereign power must intervene, not necessarily to kill those who refuse to die, but to ensure, through the use of force,

that they will be exposed to death and compelled to accept the rationing of life by the market." Montag thus describes alongside the *homo sacre*, who can be killed with impunity, the *necro-economic man*: "he who with impunity may be allowed to die, slowly or quickly, in the name of the rationality and equilibrium of the market."[16]

Timothy Haskell's "Capitalism and the Origins of the Humanitarian Sensibility" historicizes the co-ascendance of the new market form and new cognitive style of humanism that produced an abolitionist movement in Britain at the same time as large-scale, capitalist economies arose. Haskell suggests four preconditions in which problematic social issues move into the realm of moral imperatives: the expansion of the conventional boundaries of moral responsibility, an implication in the evil, a method to stop it, and technologies of action of sufficient ordinariness that a failure to use them would represent the suspension of routine. Haskell writes,

> What, then, did capitalism contribute to the freeing of the slaves? Only a precondition, albeit a vital one: a proliferation of recipe knowledge and consequent expansion of the conventional limits of causal perception and moral responsibility that compelled some exceptionally scrupulous individuals to attack slavery and prepared others to listen and comprehend. The precondition could have been satisfied by other means, yet during the period in question no other force pressed outward on the limits of moral responsibility with the strength of the market.[17]

Pharmaceutical development, manufacturing, and distribution is one crucial vein of this global history, put in particular relief in most of the last two decades. Looking at these two works together in the context of the globalized marketplace of AIDS and its therapeutic response, one that appears to require the death of some for the life of others, the infection of some for the legitimization of preventative medications for others, Haskell's differentiation between the humanitarian impulse and capitalism is prescient. Pharmaceutical grants to AIDS Service Organizations and the randomized control and clinical trials of pharmaceutical production itself demonstrate how capitalism and humanitarianism advance in tandem and serve one another's purposes. Unlike the period of moral expansion that abolitionism represented, one that saw civil society respond to this expansion in a synchronized though noncausal relationship with capitalism, "corporate responsibility" now represents the folding in of humanitarianism with capitalism. It is nothing new to recognize the immense adaptability of the market system and to recognize the adeptness of the market (and the

actors that sustain it) at the valuation of all of human action. While Haskell describes a moment when the cognitive behaviors necessitated by the market system produced a counterintuitive drive against slavery in those who adopted those behaviors, capitalism has evolved to integrate the humanitarian impulse into its calculations for market production, embedded in its very development. The necro-economic reality of the market remains, but large-scale resistance to these inevitabilities has been neutralized by bureaucratization of humanitarianism and disciplined through a rigorous field of ethics developments.

The expansion of AIDS Service Organizations, operating on budgets composed of corporate grants and government grants, both of which bring a chilling effect to any political impulses, was first noted by Cindy Patton in *Inventing AIDS*. Susan J. Shaw has since demonstrated in *Governing How We Care* how community health organizations act as neoliberal governance structures of marginalized communities, and we can see how this is only the latest adaptation of the market to humanitarian impulses in more than three centuries of refinement. Resistance hinges on once again expanding the moral boundaries within which we must act but cannot rest itself on the assumptions of the system it seeks to disrupt. As Haskell described, a new way of thinking about the value of others arises from a recalibration of economic behavior: capitalism and the necro-economic, alongside humanitarianism and biopolitics. While Foucault's first description of governmentality described a national phenomenon, it came on the eve of the global AIDS crisis, whose political, economic, scientific, technological, and cultural consequences embodied a new global age of governance when Arjun Appadurai's notion of "the social life of things" took on new networked forms characterized by disjunctures and flows of technology, ideas, media, finance, and ethnography. The types of citizenship claims made at a national level must be understood genealogically as co-occurring with global or universal claims to human rights, and this coexistence has characterized activist responses to AIDS throughout its history.

As historians, scholars, and observers of a global crisis, we must be attuned to this dual political response and the slippage between national and global claims in two key ways: First, we need to examine the way the global governance of health through public health organizations like the World Health Organization, the Global Fund, the International Monetary Fund, and the World Bank have evolved in tandem with national bodies and their national (and exclusive) goals vis-à-vis health of national or global citizens. Here we need to ask how nationalist assumptions and intranational hierarchies are

inscribed in global responses to the HIV/AIDS epidemic—attention must be paid to the failure of certain states to respond historically and the role played by the global community in approving or censuring these failures—from the United States, to Russia, to China. Second, we need to use historical thinking to situate the present in the longer tradition of national citizenship–based claims, and global or universal claims to rights. If Haskell is right that concern with the faraway other arises with capitalism, then the national and the global citizen have a long history together. How have the limits of each of these claims shaped the AIDS epidemic? When they arose together, capitalism and humanitarianism were revolutionary. Haskell reminds us that we shouldn't forget that the capitalism itself was the most expansive and enduring revolution of the last thousand years and it was operationalized in the midst of feudalism. So how did this sensibility evolve and develop under the AIDS crisis? These are crucial questions to understand where we as activist-scholars go next.

Notes

1 Stanley, "Blood Lines."
2 Robinson, *Black Marxism*, 2.
3 Gilmore, "Race and Globalization," 261, emphasis added.
4 Melamed, "Racial Capitalism," 78.
5 Melamed, "Racial Capitalism," 79.
6 Melamed, "Racial Capitalism," 79.
7 Cazdyn, *Already Dead*, 117.
8 Gao Qiang, "Speech."
9 Personal communication, 2011. Owing to the sensitivity of HIV/AIDS issues, interviewees in China declined to be named. Unless otherwise noted, the remaining quotations in my comments are from interviews conducted in 2016. My research was supported by Hong Kong University Research Council General Research Fund grant #144913.
10 AIDS Healthcare Foundation, "AHF Files FDA Complaint."
11 Curry, "AHF's Michael Weinstein."
12 Peterson, "Securitizing AIDS." This was brought to my attention by Alexander McClelland and I relied heavily on his notes and analysis of the panel in my description here.
13 Schulman, *Stagestruck*, 143.
14 See Garry et al., "Documentation of an AIDS Virus Infection"; Worobey et al. "'Patient 0.'"
15 Montag, "Necro-Economics," 14.
16 Montag, "Necro-Economics," 17.
17 Haskell, "Origins of the Humanitarian Sensibility," 563.

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